NEW JERSEY SHBP RETIREE DENTAL EXPENSE PLAN APPLICATION HD-0715-0904p

State Health Benefits Program • Division of Pensions and Benefits • P.O. Box 299 • Trenton, NJ • 08625-0299 • Fax (609) 341-3407

DIVISION USE ONLY

Effective Date: Event Reason:

Location Number

1. APPLICANT INFORMATION — This section must be filled out *completely*. Please print or type.

Social Security Number

Last Name Title (Jr., Sr., etc.)

First Name MI

Street Address (Include Apartment # or PO Box)

City State

Zip Code + 4 Date of Birth Gender

(mm/dd/yy) (M/F)

Status: ☐ - Single ☐ - Married ☐ - Domestic Partner ☐ - Divorced ☐ - Widowed

(Area Code) Home Telephone Number

2. TYPE OF ACTIVITY — ***New Enrollment Only***

☐ I wish to be covered under the Retiree Dental Expense Plan

I wish to waive coverage under the Retiree Dental Expense Plan at this time for the following reason(See Waiver information on back)

☐ I have coverage under my spouse
List Spouse's Public Employer _____

☐ I have coverage with another employer
List Public Employer _____

3. LEVEL OF COVERAGE

Select one

☐ Single ☐ Member & Spouse ☐ Member & Domestic Partner (See instructions)

☐ Family ☐ Parent & Child(ren)

4. PREVIOUS DENTAL COVERAGE

Are you currently enrolled in another group dental plan (for at least 12 months)? ☐ Yes ☐ No

If yes, please provide the following information: Dental Plan Name _____

Dental Plan Telephone Number _____

Your Member ID# _____

5. DEPENDENT INFORMATION — *List only eligible dependents.*

☐Spouse or ☐Domestic Partner — Last Name	First Name	MI	Date of Birth Month Day Year	Gender (M/F)	Social Security Number	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) (See instructions)
Eligible Children						

6. Applicant Certification — I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a pension deduction from my pension check — including initial check, last check benefit, or return of contributions check — as required by the State Health Benefits Commission. I authorize any dentist, dental care provider, or hospital to furnish my dental plan or its assignee with such dental information about myself, or my covered dependents on this application, as required. I further authorize my current dental plan, if applicable, to release information deemed necessary for enrollment in this plan. **Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under the State Health Benefits Program.**
PROOF OF ENROLLMENT IS EQUIRED. If I or a covered dependent enroll in Medicare at a later date, I understand that the State Health Benefits Program must be notified immediately.

Misrepresentation: Any person that provides false or misleading information is subject to criminal and civil penalties.

_____ _____

Applicant's Signature Date Completed

HD-0715-0904

COMPLETING THE RETIREE DENTAL EXPENSE PLAN APPLICATION

This application is for enrollment during the initial offering of the Retire Dental Expense Plan.

To enroll, complete all sections of the application.

SECTION 1 — APPLICANT INFORMATION

The retiree enrolling in the Retiree Dental Expense Plan completes this section. This section must be completed in its entirety.

SECTION 2 — TYPE OF ACTIVITY

Check only one box.

— If you are electing to enroll in the Retiree Dental Expense Plan, check the appropriate box.

— If you are waiving enrollment for yourself and any of your eligible dependents because of other group dental insurance coverage from a public employer*, you may in the future be able to enroll yourself and/or your eligible dependents in the Retiree Dental Expense Plan, provided that you request enrollment within 60 days after your other public employer group dental coverage ends — proof of loss of coverage is required.

*A public employer is a federal, State, county, or municipal government or authority; a local board of education; or a State or county college or university.

SECTION 3 — LEVEL OF COVERAGE

Indicate the level of coverage at which you wish to be enrolled. If you are enrolling a spouse, attach a copy of your marriage certificate. If you are enrolling a domestic partner see the information in the instructions for section 5, below.

SECTION 4 — PREVIOUS DENTAL COVERAGE

NOTE: The information provided in this section is subject to audit and any person who knowingly provides false or misleading information is subject to criminal and civil penalties.

SECTION 5 — DEPENDENT INFORMATION

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with level of coverage elected in section 3. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. An eligible spouse is an individual to whom you are legally married (marriage certificate required for new enrollees). An eligible domestic partner is defined below. Eligible children are your unmarried children under age 23 who live with you in a regular parent-child relationship. (This includes children who are away at school.) If you are divorced, your children who do not live with you are eligible if you are legally required to support those children. Step children, foster children, legally-adopted children, and legal wards are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. An *Affidavit of Dependency* form and legal documentation are required for these cases if you have not previously provided this to the SHBP. You will be sent an *Affidavit of Dependency,* if required, once your application is received. If you have more than 4 eligible dependent children, attach a separate application and complete Sections 1, 4, and 5.

DOMESTIC PARTNERS: A domestic partner is defined for eligibility in the SHBP, by Chapter 246, P.L. 2003, the New Jersey Domestic Partnership Act, as a person of the same sex with whom you have entered into a domestic partnership and received a Certificate of Domestic Partnership from the State of New Jersey (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships). The cost of domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for more information). If covering a domestic partner as a dependent, you must attach a photocopy of your *Certificate of Domestic Partnership* to this application if not previously submitted for retired group medical coverage. If you are retired from a local employer (county, municipality, board of education, etc.), your former employer must participate in the SHBP and must have adopted a resolution to participate in Chapter 246, in order for you to enroll a domestic partner.

SECTION 6 — APPLICANT CERTIFICATION

You must read the Applicant Certification statement, **sign it, and date the application.**

Return this application and all supporting documentation to:

NJ DIVISION OF PENSIONS AND BENEFITS
HEALTH BENEFITS BUREAU
P.O. Box 299
TRENTON, NJ 08625-0299
OR FAX TO (609) 341-3407